



RI MEDICAL ASSISTANCE PROGRAM  
PRIOR AUTHORIZATION REQUEST FORM

FAX OR MAIL TO:  
RI PA CALL CENTER  
145 Technology Lane • Henderson, NC 27537  
FAX # 1-800-390-0109

CLIENT NAME \_\_\_\_\_ DOB: \_\_\_\_\_ MEDICAID ID NUMBER: \_\_\_\_\_

PRESCRIBER NAME: \_\_\_\_\_ PRESCRIBER NPI #: \_\_\_\_\_

PRESCRIBER OFFICE ADDRESS: \_\_\_\_\_

OFFICE PHONE NUMBER: ( ) \_\_\_\_\_

REQUESTER NAME: \_\_\_\_\_ RN /MD /R.Ph / \_\_\_\_\_

PHONE NUMBER: ( ) \_\_\_\_\_ FAX NUMBER: ( ) \_\_\_\_\_

DRUG REQUESTED : \_\_\_\_\_ QTY / FILL \_\_\_\_\_

SPECIFIC CRITERIA IS AVAILABLE AT <http://www.dhs.state.ri.us/dhs/heacre/provsrvcs/mpharpa.htm> OR BY CALLING 1-866-420-3874

INDICATE THE RELEVANT DIAGNOSIS WITH APPROPRIATE ICD-9 CODE.

ADULT ONSET - GH DEFICIENCY, ICD-9 CODE \_\_\_\_\_

DUE TO: \_\_\_\_\_

OR

CHILDHOOD ONSET - ICD-9 CODE \_\_\_\_\_

GH DEFICIENT DURING CHILDHOOD AND CONFIRMED GH DEFICIENCY AS AN ADULT PRIOR TO REPLACEMENT THERAPY.

ONE OF THE ABOVE AND THE FOLLOWING MUST BE DOCUMENTED FOR APPROVAL

BIOCHEMICAL DIAGNOSIS OF GH DEFICIENCY BY MEANS OF NEGATIVE RESPONSE TO GH STIMULATION TEST.  
(E.G. ARGININE STIMULATION TEST)

COMMENTS:

PRESCRIBER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

BY SIGNATURE, THE PRESCRIBER CONFIRMS THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS  
AND AVAILABLE FOR REVIEW UPON REQUEST.

RI PRIOR AUTHORIZATION CALL CENTER FAX NUMBER 1-800-390-0109 (AVAILABLE 24 HOURS)  
RI PRIOR AUTHORIZATION CALL CENTER PHONE NUMBER 1-866-420-3874

RI PRIOR AUTHORIZATION - CALL CENTER HOURS  
MONDAY – FRIDAY 9:00 AM – 6:00 PM (EST)

PA # \_\_\_\_\_ APPROVED \_\_\_\_\_ DENIED \_\_\_\_\_ PENDING ADDITIONAL INFORMATION \_\_\_\_\_  
DATE/TIME OF RECEIPT \_\_\_\_\_ DATE/TIME RESPONSE \_\_\_\_\_ REVIEWER \_\_\_\_\_

COMMENTS: